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PART III – APPENDIX TO THE IHS 2003 PERFORMANCE PLAN

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Indian Health Service
FY 2003 Performance Plan
FY 2002 Revised Final Performance Plan
and FY 2001 Performance Report

January 31, 2002

Congressional Justification Submission

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APPENDIX TO THE IHS 2003 PERFORMANCE PLAN

A.1 Approach to Performance Measurement

Data Verification and Validation

Data validation and verification are defined as:

> **Validation** is the process for ensuring that data collected matches the intended area of performance.
>
> **Verification** is the assessment of data completeness, accuracy, consistency and timeliness and related quality control practices.

The issue of validation is directly addressed in the "Rationale" section that comes immediately after the statement of each indicator. We have attempted to use an evidence-based justification for the selection of the indicator as well as the measurement tools, particularly for clinical indicators.

The issue of data verification, however, is considerably more diverse because of the multitude of types of data that support the indicators. The verification of many of the clinically based performance indicators is supported by the IHS automated data system, and/or the IHS Diabetes Care and Outcomes Audit. The verification of data from these sources is described in the three sections that immediately follow and support indicators 1-8, 12, 13, 17, 22-24, 26, 29.

For the Capital Programming/Infrastructure Indicators 34-36, the data are recorded at the local level where projects are conceptualized based in strict protocols and formulas. These data are compiled at the Area and Headquarters level and reviewed for accuracy and then compared against similar projects. The validation and verification of this information is essential to the facilities programs since it is used to distribute resources as well as measure performance.

For indicators that survey our consumers (indicators 21 and 37), the required Paperwork Reduction Act clearance process effectively addresses both validation and verification process as required in submitting the instrument and collection protocol. We are using a similar recognized survey approach to assess Indicator 15. Surveys of our facilities about the adoption of policies and procedures for screening and referral for victims of family violence, abuse, or neglect, and staff training that support these policies are done on an annual basis. Similarly, Indicator 43, which addresses the quality of work life, is collected by HHS staff through recognized survey procedures.

The remaining indicators in this plan are process measures for which verification is less formalized. They are based on the integrity of IHS reporting structures. As an example,

Indicator 19, health facility accreditation, depends on the reports of the accrediting bodies submitted to the sites and Areas, forwarded to IHS Headquarters and reported in this document.

Data Sources to Describe the AI/AN Population

The IHS utilizes outside (non-IHS) and IHS data sources to manage its diverse programs and assess Indian health status. The two principal outside data sources are the Bureau of the Census and the Centers for Disease Control and Prevention, in particular, the National Center for Health Statistics (NCHS). The Census Bureau is the source of Indian population counts and social and economic data. However, reliable Indian census data at the county level are only available from the Decennial Census, once every 10 years. The IHS prepares AI/AN population estimates for years between the Censuses.

The NCHS provides IHS with natality and mortality files that contain all births and deaths for USA residents, including those identified as American Indian or Alaska Native. The NCHS obtains birth and death records from the State departments of health, based on information reported on official State birth and death certificates. The IHS receives these records with essentially the same basic demographic information as the records maintained by NCHS, but with names, addresses, and record identification numbers deleted as required by the Privacy Act. It should also be noted that tribal identity is not recorded in these records by the States. The State of New Mexico does identify tribal affiliation for 23 indigenous tribes of that state. However, the IHS does not obtain this tribal identification from the automated records provided by NCHS. The data are subject to the degree of accuracy of reporting by the States to NCHS. The NCHS does perform numerous edit checks and imputes values for non-responses. The IHS assigns IHS organizational (Area and service unit) identifiers to the birth and death records in setting up its Indian database. The IHS computer routines for accomplishing this have been thoroughly verified, and the results are continuously monitored.

Several studies have shown considerable miscoding of Indian race on State death certificates, understating Indian mortality especially in areas not associated with Indian reservations. The IHS now utilizes factors based on a National Death Index study to adjust Indian mortality rates for race miscoding. Moreover, there is a the time lag in receiving mortality data. These data are not typically available from NCHS until two years after the events occur, and mortality data are often slow in showing the impact of health interventions. Due to these constraints, IHS has chosen not to use mortality data for annual performance plan indicators except in special circumstances. The IHS will continue to use mortality data for tracking long-term trends in Indian health status and to make comparisons with other population groups. However, this prolonged two-year wait limits the usability of this data in the ongoing annual implementation and evaluation process.

IHS Automated Data Systems

The IHS has its own program information systems to collect data on the services provided by IHS and tribal direct and contract programs. The software used by IHS facilities and most tribal facilities is the Resource and Patient Management System (RPMS). The IHS also provides the RPMS file structure as well as technical assistance to interested tribes to facilitate importation of data to RPMS from non-RPMS sources. As a result, it is estimated that the national RPMS data set accounts for approximately 90 percent of the IHS user-population and clinical visits.

The local RPMS system supports a robust clinical and administrative data set. Local and national data are collected for a predefined data set, including inpatient discharges, ambulatory medical visits, dental visits (all patient specific) and for community health service programs. In addition, information about health education, community health representatives, environmental health, nutrition, public health nursing, mental health and social services, and substance abuse (all activities reporting systems) is collected. The PCC component (patient care component) of RPMS facilitates the collection, aggregation, display, and utilization of patient specific information. The PCC component includes many different software applications that are pertinent to the electronic retrieval of GPRA data, including lab, patient education, purpose of visit, and referral information.

This data, collected at the local level, is subject to recording, inputting, and transmission errors. However, IHS applies a series of edits at the facility and central database levels to detect and correct invalid data. Some examples include the following: when ICD-9 and CPT-4 data is input into RPMS, edit checks are conducted for sex, age, and diagnosis to prevent data from being processed that could not be true; the Medical Record supervisors have access to the medical records reports which provide the capability to check the data entered for completeness (e.g., does each visit have a provider, date of service, etc.) and flags the entries that should be edited; and when records are flagged for export, the PCC Export routine has edit checks to prevent transmission of records with incomplete data elements.

At the central database level when data is processed, additional edit checks are applied to ensure that the validity of data sorts. For example, if a report requires the gender and if the gender field is not 'male' or 'female', that record is not used. Reports are also assessed for linearity (is the data consistent month to month) and completeness (how it compares to last year) prior to sending data for review and approval. Other data quality issues that cannot be detected by computer are identified through the monitoring for reasonableness that is performed in the field, and by Area and Headquarters health program staff.

Each facility that utilizes PCC has a facility-level database that contains the detailed PCC data collected at that site. A subset of the detailed PCC data (to meet the routine information needs of IHS Headquarters) is transmitted to the IHS central database. The PCC data are the source of most of IHS' GPRA measures; these measures reflect prevention activities and morbidity and do not have the time lags described previously for mortality data. However, many of IHS' proposed measures rely on detailed PCC data that is not currently transmitted to the IHS central database. The IHS is defining additional data sets that include the data fields necessary to report on GPRA.

The IHS is also developing a new clinical software application, GPRA+. This software is designed to monitor the IHS GPRA clinical indicators at a local level. It has been developed to ensure standard data queries (through specified data logic and data fields) at individual sites. This software also facilitates ongoing local feedback on GPRA indicators based upon site-specified times, locations, and providers. IHS believes that this application will enable sites to track performance in a more timely manner, and implement appropriate responses to their results. In the meantime, IHS will still need to use sampling routines to collect the required data from the individual facility-level databases. A stratified sampling approach will be used to

include different types and sizes of facilities and Indian populations with different health characteristics.

Defining current user population is also critical to our data systems. Accurate user population data will be available by March 1, 2002. The new user population data reflects a process of eliminating duplicate patients. The current Master Person Index project is designed to ensure the identification and use of unique person indicators. This will allow for the generation of ongoing accurate user population data, as well as improved GPRA indicator data quality. This is the first step to ensuring accurate information within a data warehouse. This warehouse will become the basis for future data marts, with GPRA as a prime example of a data mart.

IHS is also planning on implementing a data quality integration project. This will ensure that national clinical indicators, regardless of etiology, will be developed in a similar manner, rely on specific data sets, and have well-defined data extract routines. This process is dependent upon a collaborative effort between the stakeholders, who represent the different data needs. However, the development of these processes will help improve data quality and reproducibility. In addition, there are ongoing workgroups (with representatives from IHS Direct, Tribal and Urban staff) to address issues of workload reporting, algorithm/formula review, data entry/coding, equity, etc.

This combination of improvements in the information technology architecture and the program improvements is starting to improve the quality and availability of data. Our information technology path is designed to increase quality data, as well as improve health care outcomes. Ensuring quality data for GPRA and performance indicators remains a major focus of our information technology development path.

IHS Diabetes Care and Outcomes Audit

A final important data set that underpins the diabetes treatment indicators 2-5 is the IHS Diabetes Care and Outcomes Audit. Since 1986 a yearly medical record review to assess diabetes care has been conducted in more than 75% of the IHS and tribal facilities, representing care to nearly 70,000 AI/AN people with diabetes. The medical staff at participating facilities are encouraged to maintain active diabetes registries using uniform definitions. Each registry is maintained in the IHS medical record system and includes information about individuals with diagnosed diabetes who have been seen at least once in the past three years. Each year a systematic random sample is drawn from each facility's registry, using a sample size sufficient to provide estimates of $\pm$10% of the true rates of adherence for that facility with a confidence of >90%.

The medical record review measures selected clinical interventions, performance measures, and intermediate outcomes using the uniform set of definitions. The Area diabetes consultants conduct chart reviews and other professional staff trained by them in accordance with written instructions and definitions provided by the IHS Diabetes Program. The abstracted data are entered into a microcomputer-based epidemiologic software program. Summary reports are printed for immediate use by facility staff in their quality improvement and program planning Activities. Regional and national rates are constructed for each item of the medical record review after data are aggregated from all participating sites.

During the period 1995-1999, approximately 150 sites submitted data to be compiled for the IHS total. Indian health facilities and tribally contracted facilities that do not provide direct patient services did not participate in the audit. Participation from each of the 12 IHS administrative regions varied by year and by federal or tribal management. All regions were represented in each year and approximately 2/3 of all the facilities contributed data in a given year. Tests of trend over the 3- year period were performed by the Mantel-Hanzel test except as noted in the text.

A.2 Changes and Improvements

FY 2003 Performance Plan

The IHS has drafted its FY 2003 performance plan based on updates in baseline data and other data related issues, the ability to address key external factors influencing success (see Section 1.4 on page 26), the level of attainment of related FY 2000 performance indicators, and the most current proposed funding level. The IHS has discontinued two indicators for FY 2002 including an indicator addressing untreated dental decay in children because of data problems and an indicator addressing maintenance and improvement temporarily to invest in the development of a more performance-based assessment process. Indicator 30 addressing tobacco control has been expanded from a focus on pilot sites to address an overall IHS tobacco control plan.

Four indicators have been added to the FY 2003 plan including:

- an indicator to reduce medication errors which supports the Secretary's Budget Priority addressing Medical Errors/Health Care Quality (Indicator 20, page 94)
- an indicator addressing organizational infrastructure efficiency and effectiveness which addresses the OMB directive on organizational streamlining and delayering (Indicator 39, page 140)
- an indicator to assure that Medicare and Medicaid claims meet the rules, regulations, and medical necessity guidance for Medicare and Medicaid payment (Indicator 41, page 142)
- an indicator to address the growing problem of nursing staff vacancies (Indicator 44, page 146)

Revisions to FY 2002 Performance Plan

The iterative process of developing the FY 1999-FY 2002 performance plans and drafting the FY 2000 performance report has been a significant learning process for the IHS. It has required the auditing of many different data sets to assess current access to health services (coverage) and baseline rates of various conditions. This iterative process continues to point to needed changes in the performance evaluation process. The table that follows summarizes the significant changes in content or magnitude to FY 2002 indicators originally submitted with the FY 2002 budget.

Summary of Changes to the FY 2002 IHS Performance Indicators

Original FY 2002 Indicator	Revised FY 2002 Indicator	Rationale for Change
Indicators 2-5: The targets for these indicators were originally based on three-year running averages. (i.e., the average for FY 99, FY 00, and FY 01 compared to the average for FY 00, FY 01, and FY 02)	**Indicators 2-5:** The targets for these indicators have been changed to compare only FY 2001 to FY 2002.	The use of the three-year running average was originally implemented because it better demonstrates trends over extended periods of time. However, because GPRA has a major focus on changes in one-year increments these indicators will now be assessed by simply comparing the target year with the previous year and will include confidence intervals once they are available.
Indicator 3: During FY 2002, continue the trend of improved blood pressure control in the proportion of I/T/U clients with diagnosed diabetes who have achieved blood pressure control standards.	**Indicator 3:** During FY 2002, maintain the FY 2001 performance level for blood pressure control in the proportion of I/T/U clients with diagnosed diabetes who have achieved blood pressure control standards.	The IHS was not able to improve its performance for this indicator in FY 2000 and also for FY 2001 based on preliminary data. It is now believed that in the face of increasing obesity rates and the +double digit inflation in the cost of appropriate hypertension medications, maintaining the current performance will be a challenge.
Indicator 8: During FY 2002, increase the proportion of AI/AN children served by IHS receiving a minimum of four well-child visits by 27 months of age by 2% over the FY 2002 level.	**Indicator 8:** During FY 2002, increase the proportion of AI/AN children served by IHS receiving a minimum of four well-child visits by 27 months of age by 1% over the FY 2002 level.	Performance level adjusted to reflect the IHS FY 2002 appropriation.

Original FY 2002 Indicator	Revised FY 2002 Indicator	Rationale for Change
Indicator 9: During FY 2002, youths discharged from Regional Treatment Centers (RTC) will: a. receive follow-up equal to or greater than the FY 2001 level b. increase by at least 5% over FY 2001, the youths who have documented 6 months of less alcohol and drug use than before treatment	**Indicator 9:** During FY 2002, Regional Treatment Centers (RTC) will be evaluated using the following criteria: --- % of youths who successfully completed alcohol/ substance abuse treatment at IHS funded RTCs --- % of youth (that completed treatment) who developed an aftercare plan with their appropriate aftercare agency --- % of youth who have this after care plan communicated to the responsible follow-up agency; documentation of this communication must be in the youth RTC record --- % of RTC programs that have a family week opportunity for youth that participate in the RTCs	There continues to be an ongoing issue of data collection, analysis and compilation. Half of the YRTC facilities utilize RPMS and the others utilize other data software systems. Transparent data extraction from different data sources to the national IHS data center still needs improvement. The proposed integrated behavioral health RPMS clinical application should solve many of these needs. Until this system is implemented, this indicator has been changed to focus on data elements that can be more easily collected at this time.
Indicator 10: During FY 2003, increase the proportion of I/T/U prenatal clinics utilizing a recognized screening and case management protocol(s) for pregnant substance abusing women by 5% over the FY 2002 level.	**Indicator 10:** During FY 2003, increase the proportion of I/T/U prenatal clinics utilizing a recognized screening and case management protocol(s) for pregnant substance abusing women by 2% over the FY 2002 level.	With the gains realized the past two years the current rate at almost 95% leaving little room for improvement. Thus the target has lowered to an achievable level.
Indicator 11: During FY 2002, increase the proportion of AI/AN population receiving optimally fluoridated water by 10% over the FY 2001 levels for all IHS Areas.	**Indicator 11:** During FY 2002, increase the proportion of AI/AN population receiving optimally fluoridated water by 5% over the FY 2001 levels for all IHS Areas.	No increases in fluoridation other than those documented in our demonstration sites have been made in the past two years and reports from Area Dental Officers and Area fluoridation coordinators suggest that increases in the number of systems maintaining fluoridated water in the immediate future will be modest until support systems are fully running in late FY 2002.

Original FY 2002 Indicator	Revised FY 2002 Indicator	Rationale for Change
Indicator 13: During FY 2002, increase the percentage of AI/AN children 6-8 and 14-15 years who have received protective dental sealants on permanent molar teeth by 1% over the FY 2001 level.	**Indicator 13**: During FY 2002, increase the number of sealants placed per year in AI/AN children by 2.5% over the FY 2001 level.	Performance level adjusted to reflect the FY 2002 appropriation. In addition, the indicator has been revised from measuring prevalence of sealant coverage to measuring number of sealants placed, because the current method used to derive FY 2001 estimates relies upon the use of codes that are under-reported and inconsistently utilized. The IHS Dental Program has determined that the most reliable and easy way to collect data for estimating the effectiveness of the sealant program is to utilize a simple count of sealants placed.
Indicator 18: During FY 2002, increase by 10% the proportion of Urban Indian health care programs that have implemented mutually compatible automated information systems which capture health status and patient care data over the FY 2001 level.	**Indicator 18:** During FY 2002, increase by 5% (two sites) the proportion of Urban Indian health care programs that have implemented mutually compatible automated information systems which capture health status and patient care data over the FY 2001 level.	Performance level adjusted to reflect the IHS FY 2002 appropriation.
No indicator at time FY 2002 President's budget was submitted.	**Indicator 20:** During FY 2002, the IHS will assess the current processes in place in I/T/Us that impact medication error reporting. a. Adopt standardized definitions for medication errors for use in I/T/Us. b. Determine where facilities are in the process of medication error reporting. c. Communicate to health care providers and administrators the need for a non-punitive medication error reporting system for all medical errors, not just medication errors or sentinel events.	This indicator has been added with the intent of improving patient safety by reducing medication errors.
Indicator 21: During FY 2002, establish baseline health care consumer satisfaction levels for all IHS Areas using an approved instrument.	**Indicator 21:** By the end of FY 2002, secure OMB approval on consumer satisfaction instrument.	Unanticipated changes in the instrument required the IHS to resubmit the materials for comment periods on two separate occasions thus delaying OMB clearance.

Original FY 2002 Indicator	Revised FY 2002 Indicator	Rationale for Change
Indicator 24: During FY 2002, increase pneumococcal and influenza vaccination levels among adult diabetics and adults aged 65 years and older by 1% over the FY 2000 level.	**Indicator 24**: In FY 2002, increase the influenza vaccination level among non-institutionalized adults aged 65 years and older by 1% over the FY 2001 level.	Because of limitations of the IHS data system, measuring pneumococcal vaccine coverage rates in adults is unfeasible. Recommendations for pneumococcal vaccine are for most recipients to be given the vaccination only once after age 65. Unfortunately, the most recent changes to the IHS data system preclude reviewing medical records older than five years making it impossible to evaluate whether patients had received vaccinations before that time.
Indicator 25: During FY 2002, expand the number of tribes/tribal organizations that meet the criteria standards of IHS comprehensive injury prevention programs from the baseline of 25 tribes in FY 2000 to at least 30.	**Indicator 25:** During FY 2002, maintain the number of tribes/tribal organizations that meet the criteria standards of IHS comprehensive injury prevention programs at the FY 2001 level.	Performance level adjusted to reflect the IHS FY 2002 appropriation.
Indicator 26: During FY 2002, reduce injury-related hospitalizations for AI/AN people by 2% over the FY 2001 level.	**Indicator 26:** During FY 2002, maintain injury-related deaths for AI/AN people at no higher than the FY 2001 level (per 100,000 population).	Efforts to assess injury hospitalizations in FY 2000 and FY 2001 revealed that the hospitalization data do not accurately reflect the number of unintentional injury cases that are hospitalized in IHS or tribal hospitals. Due to coding omissions, "cause of injury" codes are often not noted and are undercounted. Thus, while mortality are slower to secure, they are more accurate. The target has been reduced because the most recent mortality (1998) data reveals an increase and the proposed funding for FY 2002.
Indicator 28: During FY 2002, the IHS will continue collaboration with NIH to assist three AI/AN communities to implement culturally sensitive community-directed pilot cardiovascular disease prevention programs.	**Indicator 28:** During FY 2002, the IHS will continue collaboration with NIH to assist three AI/AN communities to implement culturally sensitive community-directed pilot cardiovascular disease prevention programs including: • Implementation of primary prevention indicators • Selection of behavioral and clinical measures for tracking baseline data by each Tribal site	Progress achieved in FY 2001 at the three AI/AN sites has allowed the identification of more specific performance activities for FY 2002.

Original FY 2002 Indicator	Revised FY 2002 Indicator	Rationale for Change
Indicator 29: During FY 2002, maintain ongoing body mass index (BMI) assessments in AI/AN children 3-5 years old and/or 8-10 years old, for both intervention pilot sites and non-intervention comparison sites and evaluate community acceptance and participation in program interventions.	**Indicator 29:** During FY 2002, develop an obesity prevention and treatment plan for the Indian health system that includes: ▪ a multidisciplinary stakeholder obesity prevention and treatment planning group ▪ a staff development and IT development plan to assure securing height and weight data for all system users to monitor AI/AN population obesity ▪ an infrastructure to collect, interpret and diffuse the approaches from obesity related demonstration projects and studies to IHS Areas and I/T/Us	This indicator has been expanded to address a more global and long-term IHS-wide plan to address obesity prevention and treatment based on newly released finding from research and demonstration projects.
Indicator 31: During FY 2002, maintain ongoing surveillance of HIV/AIDS and establish baselines for completeness of reporting in at least 6 additional Areas.	**Indicator 31:** During FY 2002, maintain ongoing surveillance of HIV/AIDS and establish baselines for completeness of reporting in at least 3 additional Areas.	Performance level adjusted to reflect the IHS FY 2002 appropriation.
Indicator 32: During FY 2002, increase the percentage of high risk sexually active persons who have been tested for HIV and received risk reduction counseling at least 10% above the baseline established in FY 2001.	**Indicator 32:** During FY 2002, obtain baseline measures of the percentage of high risk sexually active persons who have been tested for HIV and received risk reduction counseling in at least 3 additional areas.	Analysis of available data indicated that HIV testing rates among high risk persons are not obtainable everywhere given the existing data infrastructure, in which laboratory codes for HIV testing and testing HIV positive have not yet been standardized. To address this, a procedure is being developed for extraction from key IHS RPMS data files and mapping to a standard set of codes, so that data aggregation is possible in the future. However, until a generalizable procedure is developed, this project is proceeding on a facility-by-facility basis (as each facility has some codes that are unique).
Indicator 33: During FY 2002, the IHS will increase the proportion of American Indian and Alaska Native communities assessed by the environmental health surveillance system by 10% over the FY 2001 level.	**Indicator 33:** During FY 2002, the IHS will assure that at least 10 active tribal user accounts be initiated for American Indian and Alaska Native tribes not currently receiving direct environmental health services for the automated Web-based environmental health surveillance system.	The focus of this indicator has been redirected to the diffusion of an automated Web-based data collection system to support more consistent assessment of community environmental health services by building a more comprehensive dataset to analyze and use to determine direction. Ultimately this change will support setting specific targets for reducing environmental threats across I/T/U settings.

Original FY 2002 Indicator	Revised FY 2002 Indicator	Rationale for Change
Indicator 34: During FY 2001, the IHS will reduce $12 million of the FY 2000 Backlog of Essential Maintenance, Alteration, and Repair (BEMAR) for health care facilities.	This indicator is being discontinued consistent with recommendation from OMB.	The IHS is in the process of developing a more performance based and externally benchmarked approach to linking resources to BEMAR and access to health service.
Indicator 36: During FY 2002, assure the timely phased construction of the following health care facilities: Hospitals: Ft. Defiance, AZ-construction Winnebago, NE- construction	**Indicator 36:** During FY 2002, assure the timely phased construction of the following health care facilities: Hospitals: Ft. Defiance, AZ- continue const Winnebago, NE- continue const Health Centers: Pinon, AZ – design Red Mesa, AZ – design Pawnee, OK – begin construction St. Paul, AK – begin construction Metlakatla, AK – begin const Sisseton, SD – begin design Staff Quarters: Bethel, AK – continue const Zuni, NM – design Joint Venture Construction Program: Solicit proposals from tribes to construct health centers. Small Ambulatory Program: Provide funding to tribes/tribal organizations for new, replacement, expansion, or modernization of small ambulatory health care facilities. Dental Units: Provide dental units on priority needs basis.	This indicator has been revised in accordance with FY 2002 appropriation.
Indicator 38: During the FY 2002 reporting period, the IHS will have improved the level of Contract Health Service (CHS) procurement of inpatient and outpatient hospital services for routinely used providers under contracts or rate quote agreements to at least 82% at the IHS-wide reporting level.	**Indicator 38:** During the FY 2002 reporting period, the IHS will have improved the level of Contract Health Services (CHS) procurement of inpatient and outpatient hospital services for routinely used providers to at least 88% of the total dollars paid to contract providers or rate quote agreements at the IHS-wide reporting level.	The target was raised because the FY 1999 data became available and was at 86%.

Original FY 2002 Indicator	Revised FY 2002 Indicator	Rationale for Change
Indicator 42: During FY 2002, the IHS will support the efficient, effective and equitable transfer of management of health programs to tribes submitting proposals or letters of intent to contract or compact IHS program under the Indian Self-Determination Act by: a. providing technical assistance to all tribes (100%) submitting proposals or letter of intent based on identified areas of need and with specific technical assistance in the area of calculating contract support costs. b. reviewing all initial contract support cost requests submitted (100%) using an IHS Contract Support Cost Policy Review Protocol to assure the application of consistent standards in order to assure equitable and approvable requests.	**Indicator 42:** During FY 2002, the IHS will support the efficient, effective and equitable transfer of management of health programs to tribes submitting proposals or letters of intent to contract or compact IHS programs under the Indian Self-Determination Act by securing tribal acceptance of developed protocols for : a. providing technical assistance to all tribes submitting proposals or letters of intent based on identified areas of need and with specific technical assistance in the area of calculating contract support costs. b. reviewing all initial contract support cost requests submitted using a IHS Contract Support Cost Policy Review Protocol to assure the application of consistent standards in order to assure equitable and approvable requests.	The process of tribal consultation in critical to acceptance of the developed protocols and will require more time than originally anticipated.
Indicator 43: For FY 2002, the IHS will improve its overall Human Resource Management (HRM) Index score to at least 98 as measured by the DHHS annual HRM survey.	**Indicator 43:** For FY 2002, the IHS will improve its overall Human Resource Management (HRM) Index score to at least one point above the FY 2001 level as measured by the DHHS annual HRM survey.	Continued staff vacancy rates and the lack of improvement documented with the FY 2001 HRM have necessitated an adjustment in the performance target.

A.3 Linkage to HHS and OPDIV Strategic Plans

The IHS FY 2003 Plan was developed in the context of the IHS component of the HHS Strategic Plan and the four broad strategic objectives described in Section 1.1. From the perspective of the HHS Strategic Plan, every indicator selected directly or indirectly supports Objective 3.6 *Improve the Health Status of American Indians and Alaska Natives.* Furthermore, most indicators also address multiple other Department objectives and are listed in the "Linkages" section of each individual indicator.

A.4 Performance Measurement Linkages with Budget, Cost Accounting, Human Resources, Information Technology Planning, Capital Planning and Program Evaluation

Performance Measurement Linkages with Budget

One of the greatest challenges of implementing the GPRA in a public health program is responding to the requirements of demonstrating an outcome focus on one hand and better linkages to funding (and hence, costs) on the other. These are difficult and in some cases impossible goals to mutually accomplish. The IHS has integrated the use of process, impact and a few outcome indicators but because many health outcomes cannot be realized in a one-year plan, we have predominantly focused on activities that have an evidenced-based association with positive health outcomes over time (impact).

To attempt to enhance short-term detailed cost accounting as well as discipline specific outcome assessment capability would require the reprogramming of a significant proportion of resources away from patient care into administrative infrastructure. Such an effort would run against current trends and existing priorities. We contend given these realities, our plan meets the requirements and intent of the GPRA and adequately strengthens the connection between showing how health care funding is annually prioritized to the problems of greatest concern of our consumers. Health outcomes (i.e., mortality and morbidity) are well articulated annually in our publication ***Trends in Indian Health***, but which present data that are two to three years old because of delays in the Nations data system infrastructure.

The IHS has elected to keep general reference to funding levels in the plan and built estimated accomplishment around the request funding level. We can identify which requested funding enhancements are generally linked to supporting specific indicators in some cases. While the linkage would be relatively clear and direct in the case of public health nursing or dental care related indicators, it would get more complex with the diabetes-related indicators and extremely vague in the case of consumer and employee satisfaction related indicators. Applying a linear single path manufacturing accounting model to many health problems and management issues in a comprehensive public health program such as the IHS is not feasible.

Similarly, while performance targets for indicators addressing facilities construction are linked to funding levels in a linear way, this is often not the case for indicators addressing health care services when viewed through a one-year timeframe. Our ability to recruit additional health care providers

and having the needed clinical space available to utilize them efficiently may not be realized in a single year. In some cases, investments in the supportive infrastructure are the highest priority for long-term effectiveness but will do nothing in the short-run to increase access to services.

Another important fact that should be considered in reviewing FY 2003 performance indicators and their target levels is that the AI/AN population increases over two percent annually. Thus, service capacity must be increased over two percent just to remain at the same level of coverage each year for the indicators that set a target for the percent of the population covered. Thus, based on the proposed IHS funding for FY 2002 and FY2003, many health care related indicators have minimal target level increases or commit to the same level as FY 2002. Given population growth and the rising cost of providing services, these are challenging targets. But it is important to note that these levels of care are not likely to reverse the downward trend in health status of the AI/AN population outlined in Chart 1 on page 11 of this document.

We have selected an aggregation approach largely based on the way our programs are managed and have selected four functional areas for the aggregation of the 24 budget categories identified in the IHS "Detail of Change Table": 1.) Treatment, 2.) Prevention, 3.) Capital Programming/Infrastructure, and 4.) Consultation, Partnerships, Core Functions, and Advocacy.

While this approach may appear to be an overly simplistic "lumping" of categories, it is important to realize that there is no aggregation or disaggregation that allows mutually exclusive activities linked to mutually exclusive health problems. For a more detailed discussion of these issues, see the *Program Aggregation* section on page 42 of this document.

Cost Accounting

Beginning in FY 1997, the IHS contracted with the Mitretek Systems to analyze technical alternatives for IHS cost reporting/cost accounting. This provided a detailed analysis of technical alternatives and a cost benefit and trade off analysis of alternatives. The results have been provided to a steering committee to support strategic decision-making regarding the implementation of cost reporting and cost accounting at IHS. This system is necessary to assist IHS leadership to maximize the utility of available resources by being cost effective and ensuring that patient care can be provided to its customers.

In August of FY 1999 a workgroup met during to review, revise, and expand the cost center structure of the agency. All the current 95 cost center specifications were reviewed for content and current applications. The workgroup recommended that some of the current cost centers be deleted in future years. Several new cost centers were recommended for development. These reflect current technology, terminology and healthcare practices that will further help to delineate the agency's costs. During FY 2000 activities included the implementation of 15 new "cost centers" to improve capturing cost by functions, and sponsored 1 of 2 national training on cost principles for staff at service units, areas and headquarters The IHS also reviewed the Veterans Administration Hospital financial cost accounting system in Albuquerque, NM, for evaluation and possible adoption by IHS.

The effort, in FY 2001, also included completing "cost reports" at 22 IHS facilities, 5 tribal facilities, 10 Area Offices and Headquarters to be used for Medicare/Medicaid rate negotiation.

While cost reports represent only an incremental step toward full cost accounting, they have required that the IHS:

- Improve accounting for capital costs for facilities and equipment
- Improve accounting for inpatient versus outpatient costs for physician, physician extender and nursing

Human Resources

The IHS is committed to human resource development (HRD) and worklife improvements as an essential component of performance planning and performance management. Historically, we have invested in long- and short-term training for all staff to assure capable public health leaders, healthcare providers and administrative support. In recent years, we had reduced HRD investments in order to support other priorities. The effects of these reductions in training are undoubtedly multiple but perhaps are most evident in growing staff retention difficulties. That these two situations are related was confirmed in surveys of employees leaving the IHS. On leaving IHS, employees indicated that a lack of training opportunities (or increased opportunity for training elsewhere) was a significant determinant in their decision to leave.

Across budget categories in the requested FY 2003 IHS budget is a renewed commitment to find cost-effective approaches to better meet HRD--including clinical, public health, management, information technology, and general organizational effectiveness training--and worklife needs. Through our human capital projects we are addressing succession planning; competency and development needs of direct health-care providers; developmental needs of managers, supervisors and leaders; state-of-the-art workplace practices such as flexible working hours and workplace; and communication of organizational and professional information to support performance.

We use the Human Resource Management Index (HRMI) as an overall gauge to determine our success in meeting employee and management expectations. The HRMI measures 18 different work-related issues ranging from management culture to employee morale. The IHS HRMI score was first identified as a performance measure in the FY 2000 IHS Performance Plan (see Indicator 42 on page 143). Our overall goal is to reach the same score as the HHS population as a whole. We expect that the results of the interventions mentioned above will result in the same or a higher HRMI score each year.

Information Technology Planning

The Clinger-Cohen Act (CCA) of 1996 (formerly the Information Technology Management and Reform Act), established new requirements for the information technology (IT) planning process that emphasize the management of IT resources as a "capital investment" and link these IT planning activities to budget and performance measures. The Act reflects the growing importance that the management of IT resources plays in contributing to efficient government operations. The IHS is working to integrate CCA activities in support of GPRA efforts and visa versa.

The IHS budget formulation process is the mechanism through which the portfolio of IT investments is selected and funded. During the budget execution phase, an intensified management control process has been established to ensure performance goals are achieved, and

that IT projects are delivered on time, within budget, and perform as intended. Project updates and status on any ITSC sponsored IT project are now available on the IHS WEB site, with weekly updates on certain defined projects.

The establishment of an IT investment review process as required by CCA represents a major paradigm shift in IT planning, acquisition and management. Because of this, IHS efforts have focused on educating I/T/Us in the new IT management process and providing technical guidance in the development of IT management processes consistent with their operational and management environments.

The adoption and integration of the CMM Model (Carnegie Mellon Model) of software development is an essential part of improved IT management. This model has been extended to the organizational structure, as well as the software development process. This alignment of structure with process will facilitate our goal of reaching CMM Level 2 by the beginning of FY 2003.

During FY 2001, the IHS implemented an agency-wide IT Investment Review Board (ITIRB) and policies and procedures on IT capital planning and investment control processes in accordance with CCA requirements and Departmental guidelines. The IHS' approach to CCA implementation will follow the example of the Department in delegating responsibility and authority to the Area Directors for Area IT capital planning and investment control.

As part of the requirements of GPRA and the CCA, performance measurement is an essential part of effective management. CCA requires IHS to measure the contribution of IT investments to mission results. A key goal of the CCA is for agencies to have processes and information in place to ensure that IT projects are implemented at acceptable costs, within reasonable and expected time frames, and are contributing to tangible, observable improvements in mission performance. To effectively link strategic and IT capital planning along with the budget process, IT performance measurement efforts must monitor the performance of IT investments/projects to address whether they are effectively supporting the mission and programs of IHS.

Also during FY 2001, the Secretary has determined that HHS information technology will be managed on an enterprise basis with a common infrastructure, rather than by many separate agencies. One of the efforts underway is a unified financial management system. Specifically, HHS will have one financial management system for the Centers for Medicare and Medicaid Systems and the Medicare contractors called HIGLAS, and another management system for the rest of the department. The purpose of this endeavor is to achieve greater economies of scale, eliminate duplication, and provide better service delivery. Compared to multiple systems, the unified financial management system will reduce costs, mitigate security risks and provide timely and accurate information for management purposes. With the unified system, IHS and the rest of the department will have uniform business rules, data standards and accounting policies and procedures and a more efficient implementation as administrative support functions are incorporated.

This effort will move the Indian Health Service along with the rest of the department toward the Secretary's goal of one HHS and at the same time, support the President's Management Plan,

under the improving financial performance initiative. The unified financial management system will be beneficial in improving financial management and addressing the Inspector General concerns regarding a fully functioning integrated financial system for the department.

Capital Planning

The maintenance deficiencies for health care facilities are captured and presented to Congress in the Backlog of Essential Maintenance, Alteration, and Repair for IHS and participating tribal facilities. Sanitation Facilities Construction needs are identified and reported to Congress through the Sanitation Deficiency System. Capital asset planning for health care facilities construction is done in accordance with the IHS Health Care Facilities Priority System Methodology and submitted to OMB through Circular A-11, Preparation of Budget Estimates, Section III for reporting capital assets. These activities are represented in this performance plan by the three Capital Programming/Infrastructure Indicators beginning on page 128.

Program Evaluation

In recognition of the growing importance of evaluation in supporting the IHS Mission, Goal and GPRA performance planning, the IHS has elected to add this section addressing program evaluation for FY 2000. The IHS evaluation process seeks to include American Indians and Alaska Natives as primary stakeholders in defining the purpose, design, and execution of evaluations. Stakeholders are the users of the end product of evaluations and typically are the population or groups most likely to be affected by the evaluation findings. The IHS has worked with it stakeholders in identifying and implementing principles of responsive evaluation practice and setting evaluation priorities.

The purposes of IHS evaluation efforts are:

- to advise the Director of the IHS on policy formulation; to conduct and manage program planning, operations research, program evaluation, health services researches, legislative affairs, and program statistics
- to develop the long-range program and financial plan for the IHS in collaboration with appropriate agency staff
- to coordinate with HHS, Indian Tribes, and organizations on matters that involve planning, evaluation, research and legislation
- to develop and implement long-range goals, objectives, and priorities for all activities related to resource planning and allocation methodologies and models.

The Office of Public Health (OPH) serves as the principal advisory office to the IHS on issues of national health policy and coordinates these four evaluation functions:

- *Health Program Evaluations*--Collect and analyze information useful for assisting IHS officials in determining the need for improving existing programs or creating new programs to address health needs.
- *Policy Analysis*--Conduct analyses when a change in the IHS health service delivery system must be considered, when issues emerge in an area where no policy currently exists, or when current policies are perceived as inappropriate or ineffective.

- *Health Services Research*--Undertake analyses of the organization, financing, administration, effects, and other aspects of the IHS.
- *Special Studies and Activities*--Conduct studies and prepare special reports required by Congress in response to pending legislation or policies, often using a roundtable whenever an issue or a health problem requires immediate action and it is unclear what type of action should be taken.

The OPH meets part of the IHS evaluation needs with two major types of short-term studies: policy or program assessments and evaluation study. The policy study contributes to IHS decision-making about budget, legislation, and program modifications and includes background information to support IHS projects. Evaluation studies are carried out at the program level, or area offices, and focus on specific program goals.

Annually, OPH identifies the high-priority health care and health management issues and concerns through the submission of headquarters and area office proposals for assessment or evaluation. IHS area and associate directors submit proposals for possible areas of evaluation study. These proposals are reviewed and rated by a panel of subject-matter experts and evaluation experts and also reviewed by IHS staff for more specific concurrence with IHS strategic goals, objectives, and priority areas. The proposals are then ranked by priority and forwarded to the OPH for review and approval. The Director of the IHS reviews the final proposals and decides the respective funding levels.

Summary of Relevant Evaluations Activities

Several recent evaluation projects have significant direct and/or indirect implications for IHS performance planning and are thus summarized below:

Level of Need Funded Study Part 1: Benefit Package Costs for All Indians: This study, which is currently in draft report status, was designed to answer the question: *What would it cost to provide an equitable level of health care services to all eligible Indian people?* The research team used an actuarial analysis approach to address factors that affect the cost of providing health care benefits. The Federal Employee Health Benefits Plan was used as the benchmark for coverage and cost (i.e., premiums, co-payments, and deductibles) and adjustments were made for the population's age, health status, location, and estimated payments by other insurers (i.e., Medicare, Medicaid, and private).

The finding revealed that a health care package comparable to the Federal employee's provided to all 2.4 million AI/AN would cost $2,980 per person for a total cost of $7.4 billion annually. This same coverage if applied to the current 1.34 million using the IHS system would cost approximately $4 billion with about 25% of the cost expected to come from other sources (i.e., Medicare, Medicaid, and private). Under this model, additional resources would be needed to serve all eligible AI/AN people.

Diabetes in the Native American Population: The purpose of this project is to evaluate the effects of intensive counseling and drug management on the lowering of HgAlc's hypertension control and compliance with annual exams through a pharmacy practitioner diabetes program.

The current Santa Fe Service unit (SFSU) HgAlc average is 8.3%. This is a reduction from 9.4% in 1995. It has been suggested that this reduction is due to the increased use of metformin at the SFSU. The cost of this agent for the past 2 years at SFSU alone totaled $45,303. The estimated cost of all diabetic medication in FY 97 was $31,750. The proposed use of another new agent trogilitazone has the potential of tripling this dollar amount. The project will attempt to limit these expenses by providing intensive counseling on the use of medications, reinforcing dietary and lifestyle changes and recommended by the dietician, reinforcing the use of self-blood glucose monitoring, and adjusting medication per protocol or doctors orders. The findings from this study underpin many of the strategies used in to achieve Indicators 2-5.

Evaluation of the Behavioral Risk Factor Surveillance System's Results and their Applicability to the Native Population of Anchorage: The purpose of this evaluation study is to determine the relative accuracy, validity and reliability of the Behavioral Risk Factor Surveillance System (BRPSS) risk estimates of the Anchorage Native population compared with data collected using other techniques that include (a) door-to-door household surveys, (b) key informant surveys, and (c) intercept data collection from Natives seeking primary care services in Anchorage from the Alaska Native Medical Center and the Primary Care Center.

The findings have significant implications for the most efficient and effective approaches to delivering health services and thus achieving many of the performance measures in this plan.

Evaluating the impact of primary intervention techniques on the dental caries rate in children living in southwest Alaska Native villages: The project will identify the reason why some communities in Bristol Bay have significant higher/lower caries rates in children than do other children in other Bristol Bay communities. Children aged 6-8 have been selected for the project. Since there are multiple contributing factors from caries, multiple risk factors must be reviewed to properly assess the risk for disease. The results of the project will be used to identify the factors that create high risk communities. A community model will be developed for use in allocating specific techniques including use of fluoridated water, consistent tropical fluoride application, village education and support will reduce decay by an average of 2-3 surfaces per child at the end of those years.

Alaska Native Teen Tobacco Cessation Project: The purpose of the Alaska Native Teen Tobacco Cessation Project is to (1) help the youth who participate in the project to quit tobacco, 2) motivate the youth to become tobacco prevention and cessation advocates in their communities, and 3) determine the effectiveness of the cessation camp model in helping youth to quit tobacco. The utility of the study is to provide health educators, parents, teachers, community health aids, and other community health workers with information about the effectiveness of this particular approach to teen tobacco cessation.

This project will provide important information and strategies relevant to the development of Tobacco Control Centers as outlined in Indicator 30.

Assessing Substance Abuse Treatment Outcomes for Native Americans Residing on the Reservation: This study will provide a description of the severity of the participants' problems across eight domains (medical, legal, employment, social, drug use, psychological and spiritual)

prior to intervention, and for up to 24 months after intervention. This description will provide the basis upon which improvements of the treatment program can be made. Areas that should be targeted for specific populations will be identified. In addition, the study will produce a set of manuals documenting the interventions provided by Indian Rehabilitation, Inc., in a manner that will allow replication by other facilities.

Methodology for Adjusting IHS Mortality Data for Inconsistent Classification of Race-Ethnicity of American Indian and Alaska Natives Between State Death Certificates and IHS Patient Registration Records: The findings in this study indicate that on 10.9 percent of IHS Indian records matched to national death records, the race reported for the decedent was other than American Indian or Alaska Native. The percentage of records with inconsistent classification of race varied considerably among the IHS Areas. Recommendations included replicating the study using data on deaths occurring since 1988, using the adjustment factors developed in the study, and working with States to decrease inconsistent race reporting. While the significance of the study is not profound in terms of the performance indicators in this plan (i.e., the indicators are not based on State death certificates), the long-term significance in monitoring mortality disparities for the AI/AN population is critically important. The adjustments factors developed from this investigation are now being utilized in calculating AI/AN mortality rates in all the IHS publications.

Evaluation of the Indian Health Service (IHS) Adolescent Regional Treatment Centers: The principal conclusion based on this study's findings is that regional treatment centers have developed effective adolescent alcohol and substance abuse programs. The continuity of care and aftercare, however, is the biggest problem. The regional treatment centers need additional mental health staff resources, client charting improvements, and innovative ways to increase family involvement. Recommendations include improving the continuum of care to adolescent substance abusers, self-evaluation, and regional treatment center effectiveness and efficiency. This evaluation effort served as a major determinant in selecting Indicator 9 for this plan that addresses follow-up care for youths returning from regional treatment centers.

Evaluating the Effectiveness of Alcohol and Substance Abuse Services for Native American and Alaska Native Women: Phase II Final Report: This evaluation provides both qualitative and quantitative information about a group of women that has been traditionally underrepresented in research. The life conditions of women about whom information was gathered are extreme, and for many women, adverse or abusive childhood experiences and conditions have carried through to adulthood. The vast majority of women were exposed to various types of abuses--such as physical, sexual, and emotional abuse--from childhood to adulthood. Women entered treatment through a variety of ways. Those who were mandated tended to enter treatment as an alternative to incarceration. Women hear about the availability of services through the court system, word-of-mouth, or through a community or an American Indian and Alaska Native social service agency. Women in the focus groups tended to select their current alcohol and other drug treatment program over alternatives because of its focus on American Indian and Alaska Native tradition and culture. The women and staff also espoused the benefits of the family-like environment that the treatment centers promoted. The availability of women-centered, family-focused approaches to alcohol and other drug treatment is severely limited in the United States. Several barriers to services for potential participants exist. The leading obstacle for parenting

women is the lack of child-care for their children while in treatment. It was strongly emphasized that a woman's recovery was dependent on three key factors: herself, her social networks, and her community.

Partially based on the findings of this evaluation, this plan includes indicators which address policies and procedures for dealing with substance abusing women (Indicator 10) and for identifying, treating and/or referring victims of family violence, abuse or neglect (Indicator 15).

Prior Trauma Care of Intoxicated Patients as a Predictor of Subsequently Fatal Injury: The IHS has funded a study that includes the preliminary data collection, crude data reporting, and initial death certificate-hospital record linkage for alcohol related fatalities. The purpose of this study is to identify intervention opportunities associated with nonfatal, alcohol-related injuries reported in IHS emergency departments and clinics that could, over time, decrease alcohol-related injury death in the Billings, Montana, Service Units. This study is providing baseline data for post-intervention comparisons by expanding the existing database about alcohol-related injuries and death. The findings are being used to identify different intervention and prevention strategies directed at decreasing alcohol-related injuries and deaths in the Billings, Montana, Service Units. Injury-control efforts include a new policy regarding referrals by emergency room treatment staff to alcohol treatment staff. Prevention of alcohol-related injuries and deaths will also include activities focused on informing youth about the relationship between alcohol consumption and high-risk behavior. The findings of this evaluation effort underpin the interventions that are being used in achieving Indicator 26 in this plan addressing the reduction of unintentional injury hospitalization rates.

Resource Requirements Methodology Update: In the early 1970's, the IHS formulated the Resource Requirements Methodology (RRM) as a management tool to provide a comprehensive, systematic, and uniform process for estimating the level of resource requirements necessary to provide basic health care to IHS customers and to assist in the allocation of non-earmarked resources. To reaffirm the purpose of the RRM, a study was conducted in 1995 to determine the validity and accuracy of the present methodology for use in today's health care environment. Preliminary findings support the need to update the current methodology to meet the future program demands of the IHS. The will consist of the following phases: (1) Update Staffing Criteria and Modules, (2) Formulate Needs Assessment Cost Model, and (3) Needs Assessment Model Training. This methodology is critical to planning the achievement of most of the health service related indicators identified in this plan.

Development of a Health Services Research Agenda for American Indian and Alaska Native Populations: The IHS and the Agency for Health Care Policy and Research cosponsored a health services research conference as a first step in a long-term agenda-setting process to identify the most important health services research issues facing AI/AN communities and their health care systems over the next 5 to 10 years. The health services research agenda is intended to promote collaboration among American Indian or Alaska Native organizations, tribal and urban health systems, medical communities, foundations, and government agencies to increase communications and produce research information on health program services for the American Indian or Alaska Native patient. The health services research agenda is also intended to provide a forum for discussing health care reform changes that are creating new directions in the Indian health care system.

New Directions for Evaluation

The IHS is responding to dramatic changes taking place inside and outside the Government including greater involvement of tribal governments in the Indian health care system, technological innovations, the changing patterns of disease to more chronic conditions, and the transfer of many Federal programs and resources to individual States. These changes will affect the IHS evaluation strategy in the coming years. Nevertheless, the IHS remains committed to

comprehensively community-based, preventive, and culturally sensitive projects that empower tribes and communities to overcome health issues. Specific research and evaluation proposals currently in process include the following topics: evaluation of the effects of medical nutrition therapy on patient outcomes among Native Americans with newly diagnosed type II diabetics, evaluation of the elders clinic at the Zuni (New Mexico) Ramah Service Unit, and the evaluation of the impact of the Northern Cheyenne End-Stage Renal Disease Prevention Project.

In addition, the Director of the IHS has increased emphasis on several areas consistent with the DHHS Strategic Plan and the priorities identified by IHS stakeholders. These activities focus on women's health, youth, traditional medicine, elder care, and establishment of working relationships with Federal and State governmental agencies and will undoubtedly affect new directions for evaluation.